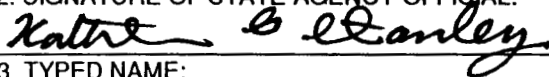

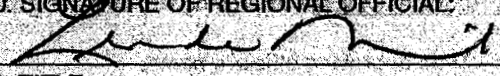


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: <div style="text-align: center;">0 0 — 0 1 0</div>	2. STATE: <div style="text-align: center;">HAWAII</div>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) <b>MEDICAL ASSISTANCE</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <div style="text-align: center;">JANUARY 1, 2001</div>	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: SECTION 1902 (r) (2) OF THE ACT		7. FEDERAL BUDGET IMPACT: a. FFY <u>N/A</u> \$ _____ b. FFY _____ \$ _____	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  SUPPLEMENT 6 TO ATTACHMENT 2.6-A		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  SAME	
10. SUBJECT OF AMENDMENT:  STANDARDS FOR OPTIONAL STATE SUPPLEMENTAL PAYMENTS			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: APPROVED BY THE GOVERNOR <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: STATE OF HAWAII DEPARTMENT OF HUMAN SERVICES MED-QUEST DIVISION P.O. BOX 339 HONOLULU, HAWAII 96809-0339	
13. TYPED NAME: SUSAN M. CHANDLER			
14. TITLE: DIRECTOR			
15. DATE SUBMITTED: DECEMBER 15, 2000			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: December 27, 2000		18. DATE APPROVED:  December 17, 2001	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2001		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Linda Minamoto		22. TITLE: Associate Regional Administrator	
23. REMARKS:			

State HAWAII

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by Federal State	Income Level				Income Disregards Employed
		Gross 1 person (3)	Couple	Net 1 person (4)	Couple	
(1) A, B, D IN DOMICILIARY CARE:	(2) X					(5)
- LEVEL I	\$530	\$521.90	\$1,590	N/A	\$1,051.90	N/A
- LEVEL II	\$530	\$629.90	\$1,590	N/A	\$1,159.90	N/A

NOTE: \*Gross income, before deductions allowed by SSI, cannot exceed 300% of the FBR.  
\*\*Net income, after deductions allowed by SSI, cannot exceed the SSI/SSP payment limit

TN No. 00-010      MAR 15 2001  
Supersedes 00-007      Approval Date: 01/01/01  
TN No. 00-007      Effective Date: 01/01/01